Forward completed form to:

Medicald Provider Enrollment Post Office Box 8809 Columbia, South Carolina 29202-8809

MEDICAID ENROLLMENT DATA INDIVIDUAL COMMUNITY LONG TERM CARE - NON-CONTRACTED

SHADED ITEMS ARE FOR AGENCY USE ONLY AND NO INFORMATION SHOULD BE ENTERED BY THE MF AID PROVIDE ITEMS IN BOLD CAPITALS MUST BE COMPLETED OR THIS FORM WILL BE RETURNED TO YOU.

ITEMS MARKED WITH AN ASTERISK (*) SHOULD BE COMPLETED BASED ON THE CODES LISTED ON THE BACK OF THIS FORM.

•			S CIG I ED ON IT 3/	ACK OF THIS F JM.
1 Medicaid No. 3 PROVIDER'S NAME	2 Provider Type 6 1	4 So	·III.	7
5 Tax Payer Identification Na	ame (If different from provider's name	<u> </u>		
				·
Physical Location Address 7 NUMBER AND STREET				
9 CITY		10 STATE 11 ZIP+4		
			ПНТТ	
Payment Address (If differe	nt from mailing address)			
6 in care of, Attention, Buildin	g Name, etc.			
8 Number and Street, PO Box	or Poute No			
	TITITITITI			
12 City		13 STATE 7+4		
			HIL	
15 COUNTY* 16 T	ELEPHONE (II) UDE AREA COL.	TILLIII.	-OR-	18 SOCIAL SECURITY NO.
19 EC Indicator	20 Type Ow.		Enroll Status	23 Enroll Date
24 NPI NO.	SUE DATE			
26 TAXONOMY CODA	Tr comy Code	Taxonomy Code		
ATTENTION: A statistically valid rance molino inique with extrapolation may be used for determining overpayments/underpayments/u				
any change affecting my enrollment information necessary for process	is form, that the enrollment info en in their certify that I will obtain a dicaid claims.	the reverse side of this form, to ormation I have furnished is true uthorization from each Medical	hat I understand and a b, accurate, and comp d patient to release to	egree to the conditions lete and that I will report SCDHHS medical
Signature and Title of Authorized A facsimile stamp is not accer	, <u> </u>		Da	te